Interview with RADM Ben Eiseman, MC, USN (Ret.), Former Surgical Consultant to the Surgeon General of the Navy, conducted by Jan K. Herman, BUMED Historian, Denver, CO, July 18, 1990.

If it could be said that the Navy has a dean of combat surgeons, RADM Ben Eiseman, MC, USNR (Ret.) certainly deserves that title. During a Navy reserve career that began during World War II and then spanned some 34 years, Dr. Eiseman probably saw, assisted, or operated on more combat casualties than any other surgeon in the U.S. armed forces. When he wasn't sprinting across the invasion beaches of Normandy or Okinawa with the Marines, he was serving as surgical chief at several leading hospitals, teaching surgery both here and abroad, and writing literally hundreds of articles and several books. As the U.S. commitment grew in Vietnam during the mid-1960s, Dr. Eiseman's almost legendary experience became a precious commodity. Surgeon General of the Navy, VADM Robert B. Brown [1965-1969] called then CAPT Eiseman back to active duty to be his surgical consultant. As the Surgeon General's eyes and ears in Vietnam, Eiseman played a unique role. Just over two weeks after this interview was conducted, Iraq invaded Kuwait, and much of what Eiseman discussed in that interview took on special significance. During the Gulf War, the then 73-year-old surgeon again served as a consultant, this time to the U.S. Army hospitals in Germany, and at several Army medical units in the continental U.S.

Jan K. Herman: How did you become Surgeon General Brown's eyes and ears in Vietnam during that war.

RADM Ben Eiseman: Bob Brown was one of the first Surgeons General who had true academic credentials. He was a product of the University of Pennsylvania Medical School and a protege of Dr. Isidor Ravdin, Chairman of Surgery at Penn. Brown was a member of the Society of University Surgeons and was highly respected in the inner club of academic surgeons. I always had ready access to him because he knew I was interested in trauma and was a member of the National Research Council Committee on trauma and shock. When we'd meet I'd talk with him about the ways I thought the Navy and the military should keep abreast of advances in the treatment of trauma and the problems of tropical medicine, which was also of interest to me.

Bob also knew that I had spent some time in Southeast Asia going all the way back to 1950. I had been all over Thailand and had been to Laos and had cared for casualties when the French were still there, as well as having been visiting professor at medical schools in Thailand. He knew that I had a lot of contacts in Southeast Asia. So when the Vietnam war began to heat up, Bob and I would see each other quite frequently. I was a captain in the reserves at that time. I suggested a closer liaison between the Navy and the large number of reservists that were being called up and sent over to Vietnam.

At the time I was professor and chairman of the Department of Surgery at the University of Kentucky. Indeed I used to rotate my residents through the Marine Corps and the Navy. One time during the Vietnam war I counted 15 of my residents who were active reservists. It was therefore natural that he asked me to be surgical consultant to the Navy and Marine Corps. I was delighted to do it. When Dienbienphu was about to be surrounded in 1954 [the surrender of French forces at Dienbienphu signaled the end of French colonial rule in Indochina], I was asked to go there by Donovan [General William Donovan formerly of the Office of Strategic Services] to find out what was going on from a medical standpoint. The Americans weren't involved and we couldn't officially have anything to do with it. I couldn't go at the time and I often wonder what might have happened had I accepted Donovan's suggestion.

When it became evident that Vietnam was evolving into a good sized war in the early 60s, I felt a lot of emotional involvement. I had trained many Thai surgeons at Washington University in St. Louis under an exchange program between Washington University and the Thai medical schools. Sometimes I would have 20 or more Thai doctors at various specialties under my administrative aegis in St. Louis and in other universities.

Anyway, Bob Brown asked me to go to Vietnam as his surgical consultant and I willingly agreed. I had known the surgical consultants in Korea as well as those in World War II, such as Dr. Edward D. Churchill, who had been my boss at Harvard and had become the surgical consultant in the Mediterranean theater when I was a very junior medical officer with the amphibious forces.

When Admiral Brown asked me to be the surgical consultant in Vietnam, I went to Boston and talked with Dr. Churchill and asked him for advice.

What kind of advice did he give you?

He said the best thing to do was to get as open ended orders as possible from the Surgeon General and then to go as far forward as possible, find the most junior medical officer around, and then just listen to him. Each time I went to Vietnam that's exactly what I did. The Surgeon General gave me carte blanche. He had me write my own orders and let me go where I wanted. I took every opportunity to spend a day or two working in the field with the Marines.

What makes a good surgical consultant?

You first must know something about the military. Marines speak a different language than ordinary folks. Only by knowing the military can you get anything done. Most importantly, in a forward unit you must know how to minimize chances of getting injured or killed. You can't just take a good trauma doctor or a good infectious disease doctor and throw him into a combat zone and call him a consultant. I had one of the early tape recorders and every day or so I would record my impressions and mail them back to the SG. When I got back I wrote a long report.

The surgical consultant must be an active surgeon. If he rolls up his sleeves and takes his turn operating, then young doctors will listen. There was an illustrative episode in Saigon. A hotel was blown up right near us. I went to work in an Army evac unit nearby. There was a young reservist there and I helped him do a laparotomy on a penetrating injury of the abdomen. As the surgeon began to close the wound I said, "Leave the skin open." He responded, "No, Colonel. I've just finished the surgical residency at King's County Hospital in Brooklyn and Dr. Dennis told us to close in this fashion with catgut and close the skin." I said, "Look, close with wire and leave the skin open." He said, "No. I'm going to close the skin." I said, "I could give you an order but that wouldn't do any good. Maybe this will get it across to you. Have you passed Part II of the American Board of Surgery?" He said that he hadn't. I told him that I was on the American Board of Surgery Examination Committee. "Leave that goddamn skin open. Now do you understand?" "Yes sir!," he responded.

The reason I bring up this story is to emphasize that the surgical consultant must have clinical and academic credibility because often the front line guys are reservists. They have come from a highly academic background where they've had a keen interest in learning. They inevitably look at regular medical officers, right or wrong, as a cut below their teachers at home.

If you can approach them as one of their teachers and with a little bit of rank, that equates with more authority.

They called you colonel?

In my entire 34-year career, I was always with the amphibious forces in landing craft and with the Marines. The only time I was ever on a big ship was on one occasion went I went to pick up the mail for our flotilla of landing craft on a carrier during World War II. There was one other time when I went through the Suez Canal on a British carrier. I was almost always in greens. My specialty was in combat casualty management.

In Vietnam I would continually go out--get a chopper ride--and go out to a battalion and hunt up the one or two medical officers in that battalion. I would simply ask them what was going on. "What have you learned? What can we do differently?" Ask them what they thought about the way things were being done.

It must have been a tremendous morale booster for them when you came and showed that someone cared about what they were doing.

I know it was. It made them think they weren't forgotten. They knew I was the Surgeon General's representative, and what they told me would get back to the Boss. Naturally I also worked with the theater and division surgeons.

Once we were attacked by mortars. One of the surgeons took a fragment that nicked the top of his nose. It didn't do much harm even though it came centimeters from killing him. I got on the radio and got the word back to the SG that this lieutenant had been wounded, but that he was perfectly okay. The SG immediately got on the telephone and called the family and within hours their minds were put at ease. It is with unofficial, small matters such as this where a consultant can help the SG.

One of the other things I think a surgical consultant should do is to ask questions that might be awkward for those who fear that their careers might be jeopardized should they bring up unpleasant ideas. Academic surgeons are trained to ask questions and perhaps are particularly suited for the consultant's job.

An additional role for the consultant is to help the medical officers in forward areas to put their frustrations, disappointments, and fears in perspective. This, of course, requires that the consultant himself has been through a war or two in a junior role himself--and is empathetic.

There are many frustrations for such surgeons including such items as large numbers of wounded requiring short periods of contact in contrast to the more leisurely technique available in civilian practice. There obviously is the inevitable need to evacuate a casualty toward the rear rather than providing total, definitive care. The doctor must do without some of the technical niceties he has become accustomed to in civilian practice.

In the military setting, the lack of equipment or supplies is a favorite outlet for frustration when things go wrong. A surgeon may miss a special instrument upon which he relied, or a diagnostic modality such as a CT scan, or monitoring equipment of some new and sophisticated design. Lack of such technical help is a favorite whipping horse when things go bad. A good consultant can point out to the frustrated surgeon the small incremental benefit of such devices, showing that the ultimate outcome of even severe injuries seldom depends on such items.

What is the surgical consultant's role in stimulating research and innovation?

The most important part of a successful research project is asking the right question. A productive wartime consultant in a combat zone is one who has been trained to recognize the unusual and to ask the proper scientific and clinical questions of the unusual clinical environment that constitutes combat casualty care. The consultant should be accustomed to inquiry--a state of mind that at best is associated with a clinician who has selected an academic career. He should also be accustomed to the routines of combat casualty care, so that he can recognize the unusual. A neophyte is for some time overwhelmed by the sheer mass (and terror) of caring for dozens or hundreds of casualties a day.

U.S. military history bears out this thesis. Weir Mitchell was a consultant in the Civil War when he pioneered his studies on causalgia. Cannon's seminal work on shock and Evarts Graham's work on empyema in World War I were performed during their duty as consultants. In World War II it was Churchill, Burford, and Sampson who, as uniformed consultants, discovered the benefits of operation for clotted hemothorax. In our own time, the clinical approach to ATN in Korea or the advances in frozen blood in Vietnam, or Adult Respiratory Distress syndrome, or Multiple Organ Failure were all made by academicians either in or out of uniform acting as consultants.

How do you account for the enormous advances made in wartime medicine?

In fact, almost none of these advances were actually made during war. They were applications of discoveries made in between wars to the large numbers of casualties and the unusual conditions of a combat situation. Take penicillin as an example. It was discovered before World War II. The enormous demand of its use sponsored advances in mass manufacturing, but the discovery preceded the war.

Indeed, the wise consultant in any future war should survey recent advances in every branch of clinical medicine, and then be alert where and how such advances can be applied in a combat theater. I did this consciously before I first took up my duties in Vietnam.

Can you give an example of how this worked?

I can give you two, one clinical and the other more experimental. On one occasion I was riding in a truck convoy in the I Corps area in Vietnam toward a forward area where a fire fight was in progress. The truck in front of ours hit a buried mine and the marine in the front seat suffered a dislocated knee. We took him to Charley Med outside Danang, reduced the dislocation, but then identified an absent pulse. We performed a femoral arteriogram using a simple needle stick and a one-shot dye injection into the femoral artery. There was a block at the popliteal space, which we repaired operatively. This was the first time such a technique had been used in the I Corps, and perhaps in the Vietnam theater, even though it was a reasonably well known procedure by that time in civilian practice. It was innovative in the military sense but certainly not in a scientific sense.

A more complex example might be the then puzzling observations of pulmonary edema that occurred following severe injury and resuscitation in Vietnam. In retrospect, this seems obvious that what we observed was simply Adult Respiratory Distress Syndrome. As with most problems, however, it was far from easy at the time. It took both clinical and laboratory research carried out by many of us to get the answer to what was then called "Danang Lung."

Did you ever encounter medically unusual signs or syndromes in combat casualties?

I can remember seeing patients brought out of the field in Vietnam a few minutes after being hit. When examined they were shivering, despite the tropical heat. We remarked about this and, of course, now know that such hypothermia occurs perhaps because of the early neuroendocrine response. At the time, however, this seemed odd, odd enough to spur on a lot of subsequent work on how the body responds to injury, blood clotting, and other physiologic responses.

You have been associated with the military in several wars and in various capacities. As you review your experience, do you have any suggestions to those who may face combat zone medical duty in the future?

I would say that such young doctors should look at this experience as an enormous challenge, both personally and professionally. The doctor must be ready to improvise. We tend to become spoiled in the luxury of our 20th century American lives. Duty in a forward unit brings us back to what most of the world's population encounters on a daily basis. Everything we want will not be available. Sometimes some real Yankee ingenuity is needed to get the job done.

It sounds like there's a story behind that remark.

Well, there is, although in retrospect I'm not entirely proud of the episode. Before the Normandy Invasion in World War II, I was assigned to a beach battalion and was scheduled to take care of casualties on an LST after getting off the beach. The LSTs had no operating areas, which I thought should be provided. It so happened that I found some "unused" steel lying on a dock, unofficially "requisitioned" it, and with some help welded together a raised operating room on the after end of the tank deck. It was the only time I was ever threatened with a court martial during my Navy career. They, of course, dropped the charges, for within days I was headed for the beach. It so happened that we used the operating area for early treatment of several penetrating injuries of the abdomen and chest, but you will not find any operating rooms described on the after end of landing craft.

How many trips did you make to Vietnam?

I went over twice during the war. The second time I went down to the Mekong Delta to see what was going on with the riverine forces. At that time, no one had taken a look at casualty management in the delta war and I actually got to go on some of the operations both with U.S. and Vietnamese forces.

Down in the Delta there was no doctrine for riverine warfare. The last time the American armed forces had any riverine experience was in the Red River campaign in Arkansas during the Civil War. Of course we had total air cover in the Delta and we could have choppers land even on small craft for casualty pickup. As we would go up these narrow channels, we would get fired upon and there were on occasion five or six casualties in the lead or second boat. But we had such overwhelming firepower that we could push on through.

Did you ever accompany any of the helicopter medevacs?

Several times, both on routine pickups and a several time on so-called "hot pickups" from an active combat zone. Indeed, I made some strong recommendations to the Surgeon General that we modulate the call system for helicopter pickups for it was clear to me that we were putting too many helicopter crews at risk for what turned out to be surgically unnecessary reasons. At one extreme, the corpsman at the scene of the fire fight, quite understandably, wanted early evacuation of even the most minor casualties. He would call for a chopper which would almost always routinely come regardless of the nature of the wound. Many of the injuries could have waited an hour or more without danger to the casualty. At the opposite extreme, I can remember a commander in the Medical Corps who got the Navy Cross for going in with choppers to pick up casualties under fire. I personally saw four of the five casualties picked up dead on arrival.

Judging the seriousness of an injury and the need for immediate evacuation is a complicated clinical decision and one cannot blame a corpsman under fire for errors in judgment. This remains a problem which in part can be solved by good communication with a medical regulating center, but will always depend on the corpsman's judgment.

You once mentioned in an article that the next war is not going to be like Vietnam.

I think it would be hazardous in the extreme to assume we will have unfettered command of the air in the next war, be it from competing airplanes or from hand held or fixed missiles. I think we should be ready to use any advanced technology possible but that we must continue to have sufficient ground evacuation back as far as is necessary for a safe air pickup.

Have you had much experience on hospital ships?

Of course I have been on hospital ships numerous times, but I have never been assigned duty on them. My active duty time was always with either the marines or amphibious forces. It seems to me that there really are two roles for the hospital ship. It should either be used before we have hospitals ashore or should function as a base hospital referral center from fixed smaller hospitals ashore that do not have the specialists or complex equipment available on the ships.

Once I recall that LCDR Jim Chandler and I were the only surgeons in Chu Lai when we received over 300 casualties within a 24-hour period. He and I operated around the clock for lifesaving requirements, used all the general medical officers we could gather for triage, and shipped as many casualties as needed to the hospital ship which was steaming offshore. It was the classic role of a hospital ship used in World War II, Korea, or indeed, the Crimean War by the British and French, except that we used helicopters instead of boats.

How do you train civilian or peacetime active duty surgeons to manage combat casualties?

This is an important and recurring problem. Because of the inevitable turnover of medical personnel in the military, the corporate memory of the Medical Department is short and very few military officers deployed to a new theater of combat will have ever seen or cared for a casualty under combat circumstances. A few might have had experience in a trauma unit during peacetime, but wartime injuries and, even more importantly, wartime evacuation policies, make an enormous difference in how such casualties are managed.

In my mind there are two essentials in training future medical officers to function in a combat theater. The first is to teach fundamental principles of trauma and wound care to young physicians and surgeons. This includes the body's reaction to injury, principles of hemostasis, the immune and cytocrine response to injury, principles of wound healing, and the physiology of repair. I realize that I'm speaking as a professor of surgery in this matter, but with a good background in principles, a smart physician can soon adapt his environment and the tools he has at hand to provide the best care possible.

The second method is to make optimal use of what personnel you have who have had personal experience in combat as instructors for those being deployed. This is often not easy, but as I have indicated elsewhere, perhaps this is an important role both for reservists and consultants. There is, incidently, relatively little interest among even surgeons in learning about the problems of working within an evacuation system until the guns begin going off. Then there's a frantic scramble to learn.

Hasn't the growth of civilian trauma centers changed this a great deal?
There is no question that a surgeon who has worked in a trauma center has a great deal of knowledge of how to manage an individual casualty, or even a few at a time. But even they are unfamiliar with the impact of having to evacuate patients simply after physiologic stabilization, or within a day or two after surgery. Indeed, such specialists may be the most difficult to teach to do as little as possible forward before sending the casualty to the rear. Trauma specialists are accustomed to being in a center and receiving patients evacuated by others. They are used to performing the definitive operation themselves; it seems unnatural for them to do otherwise.

Did you ever serve in Korea?
Although I visited there during the Korean war, I didn't have much to do as an activated reservist during that war. In addition to my peacetime career in academic surgery, I spent a good deal of time working for various organizations both civilian and governmental in Southeast Asia.

Why weren't you recalled to active duty?
You may recall that reserve medical officers were not activated during the Korean war. The Department of Defense relied on the doctor draft, which to my mind was a bad error.

Wasn't this also the policy during Vietnam?
Yes, and once again it was an error for it destroyed the entire logic of a reserve force. If the reserves are bypassed and reliance made on a doctor draft, then why spend the money on a reserve?

What was the reason for not calling up the reserves?
It was a political decision. Calling up the reserves was considered a signal of escalation to the Russians and Chinese that might trigger them to enter the war in Southeast Asia.

I would like to go back to your World War II experience. You went into the Navy right after you graduated from Harvard and had a 9-month internship in surgery at Massachusetts General Hospital?
Yes. As soon as the truncated surgical internship was over, I was sent to Lido Beach on Long Island. It was a cold, blowing, snowy day and we trudged through the sand to a big shed, where we were separated into two groups, one of which was made up of those of us who were single and had 9 full months of surgical internship. We were dubbed "combat surgeons," a sobriquet that had ominous overtones. We were immediately given duffle bags and marched down a long supply line in which all sorts of combat gear was thrown at us. Some was for tropical weather, indicating that we were headed for the Pacific. Other gear was for cold weather so we might also anticipate European duty. At the end of the line we were issued pistols, despite a few tiny voices who reminded the amused supply sergeant that we were doctors.

About 40 corpsmen who had been organized into a beach battalion were then assigned to us and we all marched off to the railroad station with sealed orders. Mind you, we had no preparation. We didn't know how to march but just trudged along beside the corpsmen. We certainly hadn't the slightest idea how to salute or whom to salute.

When we got on the train we opened the orders and I found that I was headed back to Boston. Any visions of a long stay back among friends were squelched when our railroad car, which had been sealed from the passenger cars, was detached and shunted off to the dockyard. We pulled up alongside an LST, were hurriedly shoved aboard, and within an hour were at sea. I had not been in uniform a week.

You landed with your beach battalion on Normandy on D-Day. What was it like?

Perhaps it was best explained by the remarks of a colleague after we brought our first load of casualties back to England shortly after the initial landing. We went to a bar to have a drink before returning to Normandy. A British gentleman came up to us and said, "Pardon, but I believe you have been over on the beaches. What's it like?" My friend turned and said, "It's terribly noisy and there are crowds of Americans."

In fact, I did very little that any good corpsman could not have done as well. My job was to run across the beach with a six-pack of whole blood on my shoulder. Six units of blood is heavy and I can well remember how it cut into my shoulder and slowed me down, particularly when I dived for cover when an explosion went off nearby. I spent the day and next night underneath a cliff just beyond the sand, doing little more then first aid and giving IVs. As soon as possible, we sent the casualties back to the ships on LCVPs (landing craft, vehicle and personnel). I understand that this was the first use of whole blood on an amphibious assault.

How many times did you go back and forth to Normandy?

I don't recall exactly, but I think it was between six and eight times. We would go forward to pick up casualties at a clearing station, take them back, load up, and go to England. Once I switched to a freighter that had hit a mine in mid channel and took off casualties. We lightened the load of their refrigerator before the ship sank and we got back onto our LCVPs and headed for England.

On another trip we were going through the Straits of Calais headed for Tilbury when a small plane came over at no more than a few hundred feet going like the devil. It did not waiver despite our antiaircraft fire but kept on in the direction of London. A British major standing by my side said, "You know that is some sort of new plane and I am going to report it." It turned out to be one of the first V-1 pilotless buzz bombs.

Did you do much operating once you got back aboard the LST?

Very little for two good reasons. First it was not the appropriate thing to do. If the casualty required surgery, he should have been kept in France and operated on there. If not emergent, the operation should have been postponed until they got him to a hospital in England. The second reason was that I was a very inexperienced "surgeon" with only 9 months of internship under my belt. On one occasion I had to do an abdomen, when a fellow took a round through the belly. There were some German prisoners aboard and so I rounded up some German corpsmen to help my own. We used the steel and canvas self-made OR on the tank deck. I slipped in a spinal anesthetic, quickly rolled the chap over on his back, cleaned his belly, and did a laparotomy sufficient only to sew up an obvious hole in a piece of small bowel. Then I closed before the anesthesia wore off, which was what really scared me.

Didn't you resect the bowel?

No, for I had never done so, except on a dog in our sophomore animal surgery course. Secondly, the hole was mercifully small. The chap lived, but had a fistula that developed about a week later in Portsmouth Naval Hospital in England.

What did you have in the way of a surgical kit?

We had a khaki roll of instruments with a complete set of hemostats, retractors, and the like. I came to know them well, for in the Pacific, they issued us each a new kit for every invasion. When I inquired why, they explained that both the kits and ourselves were written off as expendable for each invasion. I brought one of the kits home and used it in one of my early dog laboratories doing research in Denver after the war.

What did you do in the Pacific after you were transferred there?

I went directly from Europe to the Pacific after a 2-day layover in the U.S. and then through the Panama Canal. I made several landings in the Philippines, and put in at Peleliu shortly after the shooting stopped there. Okinawa was my big campaign in the Pacific.

We were being sent back to load up for the invasion of Japan when the bomb was dropped and the war ended. When I hear those who decry the use of nuclear weapons on Japan, I often wonder what my chances would have been had the bombs not been dropped. I would have been on a beach battalion for the Japanese landings.

By the time the war ended you must have had a pretty good grounding in surgery.

No, not in surgery. I had a lot of interesting experiences and learned a lot of handy things such as how to navigate, how to shoot an antiaircraft gun, and how to survive in a combat situation, but not much about operating or clinical surgery. I was never assigned to a hospital. Most of all I learned how nice it was to be alive and young at heart.

When I took up my surgical training, I started all over again, but I certainly didn't resent this. After all, as I have told many a young medical officer since, the military medical department during wartime is not primarily or even secondarily a teaching institution. I have had little sympathy for those who complain that their surgical education is interrupted by serving on active duty for a couple of years during a war.

I obviously liked my military experience, for I kept my commission for 34 years before retiring. I started out as a j.g. and went up as high as I could go in what my grandchildren and children call "upward failure." Yes, it was a career pattern of upward failure.